

# **HARP Chronic Disease Management Guidelines**

## Preface

The impact of chronic disease is significant for the individual and their carer(s) as well as the health care system. The Hospital Admission Risk Program (HARP) was established in 2001 to address sustained increases in demand on the hospital system.

The HARP Chronic Disease Management Guidelines (CDM) have been developed by the Department of Human Services (DHS), in consultation with the HARP Planning Group. The guidelines aim to provide health and community services with direction for transitioning HARP projects to a HARP Chronic Disease Management Program over the next few years.

The HARP CDM Guidelines have been developed to facilitate effective service provision and reduce avoidable hospitalisation for:

- People with chronic heart and respiratory disease; and
- People with complex needs requiring integrated care.

Services for clients with these specific issues are provided across the health care sector, including public health, primary health, sub-acute and acute health, depending on client issue severity or intensity.

This is an exciting phase, where the tremendous work of those involved with HARP projects becomes embedded in the Victorian healthcare system. DHS looks forward to working collaboratively with health and community providers during this phase. Together we can improve the health outcomes for people living with chronic disease and complex needs.

## Acknowledgements

The HARP CDM Guidelines have been produced by the Metropolitan Health and Aged Care Services Division, Department of Human Services.

Many people and organisations gave their time and support in the planning and formulation of the guidelines.

In particular, we wish to acknowledge and thank Ms Kaylene Fiddes and members of the HARP Planning Group.

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## Strategic Directions for HARP Chronic Disease Management

HARP Chronic Disease Management (HARP CDM) will focus on continuing to improve the management of people with defined chronic diseases and complex needs who frequently use hospitals or are at risk of hospitalisation. HARP CDM involves embedding models of care that have emerged through HARP from 2001 to 2004 into the Victorian service system.

DHS has developed this way forward in light of the achievements of HARP. HARP was established to address sustained increases in demand on the hospital system. The factors contributing to demand include an ageing population, new treatment options, reduced General Practitioner (GP) availability, residential care bed shortfalls, workforce shortages and a reduction in the capacity of informal carers.

HARP has reduced the growth rate in demand for acute services. Achievements have included improved identification and proactive management of at-risk patients, increased health system capacity and greater collaboration between services. For the clients, some of the benefits have been improved health outcomes, empowerment through education and self-management strategies, individually tailored care and the chance to stay at home for a longer period.

We are moving from a focus on 'innovation' and 'experimentation' to embedding successful models of care within the service system. To support this transition, DHS has identified key elements of successful models of care from which HARP CDM Guidelines have been developed.

The future directions for HARP CDM will change the traditional care experienced by people with chronic diseases and complex needs who have a likelihood of preventable hospitalisation. It will continue to increase the capacity of the service system to address the continuum of care by linking acute and primary health care and social support.

### **HARP Chronic Disease Management Mission**

Our mission is to create an integrated, effective and sustainable chronic disease and complex needs program, which provides the right care in the right setting, to reduce avoidable hospital admissions and contribute to better health outcomes for Victorians.

The key objectives of HARP CDM for the defined target groups are:

- **To improve patient outcomes;**
- **To provide integrated seamless care within and across hospital and community sectors;**
- **To reduce avoidable hospital admissions and Emergency Department presentations;**  
**and**
- **To ensure equitable access to healthcare.**

HARP CDM will be developed to complement the rich and overlapping policy environment of both the Victorian and Australian Governments' health care reforms. *Directions for your health system: Metropolitan Health Strategy* identifies an expanded role for ambulatory care services as a cornerstone in the configuration of health care services. The *Ambulatory Care Policy and Planning Framework* will provide clear policy directions and an overarching planning framework for ambulatory care service delivery models and facilities in Victoria. Primary Care Partnerships (PCP) are collaborating to improve the health and well being of their catchment's population through improved coordination of planning and service delivery. Other relevant state policies or initiatives include *Community Health Services: creating a healthier Victoria*, *Improving Care for Older People: a policy for Health Services*, *New Directions for Victoria's Mental Health Services: the next 5 years* and *HealthSMART*.

More broadly, a number of Australian Government initiatives provide the opportunity for integration with HARP CDM, including the Coordinated Care Trials, Chronic Disease Management (CDM) Medicare Items (previously known as Enhanced Primary Care or EPC Items), the Strengthening Medicare initiative, the National Medicine's Policy, the Asthma 3+ Visit Plan and the National Health Priority Areas Initiative.

The target population for HARP CDM are those people who are most likely to benefit from integrated care and have the potential to reduce avoidable hospital use. This includes:

- People with chronic heart disease;
- People with chronic respiratory disease;
- Older people with complex needs; and
- People with complex psychosocial needs.

Evidence shows that these groups are 'people who frequently use hospitals or are at risk of hospitalisation'.

Eight core principles underpin the key values central to HARP CDM. They are considered essential to establishing an effective service system.

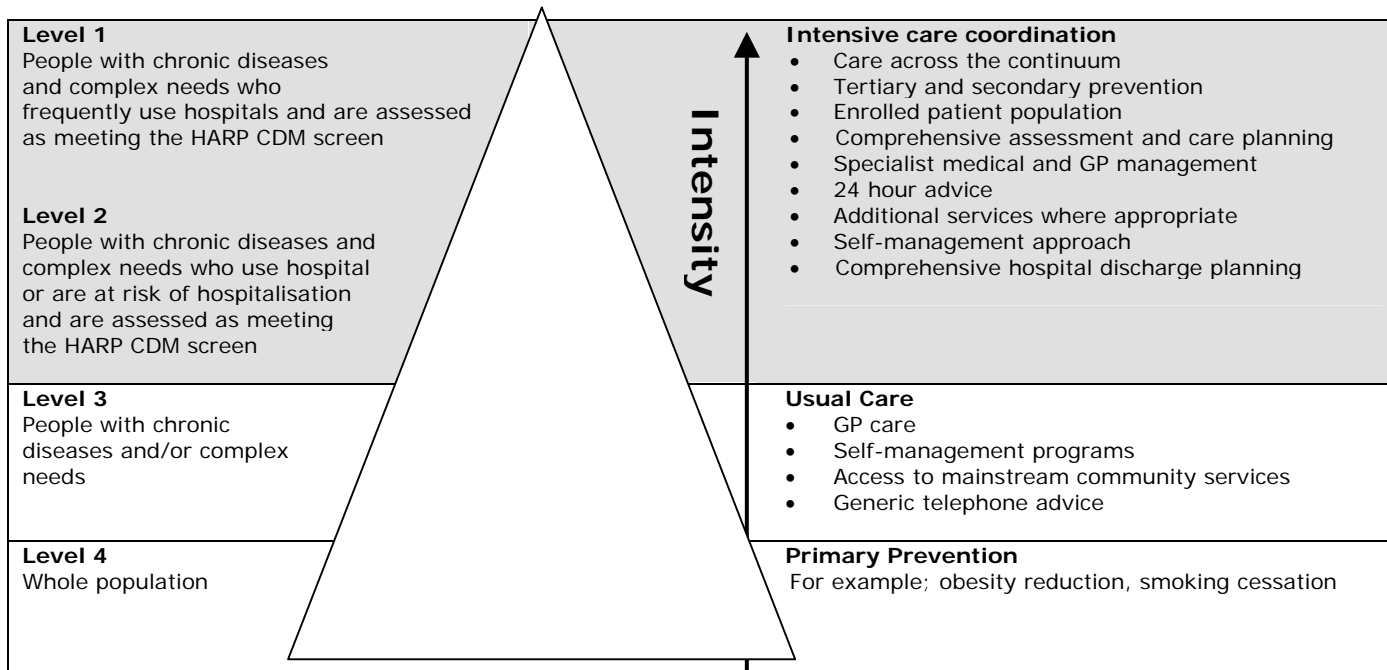
- 1. Client-centred**
- 2. Carer involvement**
- 3. Collaboration**
- 4. Integration**
- 5. Leadership**
- 6. Workforce Development**
- 7. Evidence based practice**
- 8. Quality**

Collaboration and integration across the care continuum are key success factors for providing an optimal experience for those people with chronic and complex needs. The Department believes that to provide integrated seamless care the inherent competencies and capabilities of the acute, sub-acute and community sectors must be leveraged. It is imperative that HARP CDM establish effective working relationships with other programs including, but not limited to, Emergency Department Care Coordination, General Practice Liaison Units, Diabetes Management Initiatives, the Respecting Patient Choices Projects and Post Acute Care.

HARP CDM will encourage the ongoing growth of partnerships between health and community service providers. Local alliances will work together to develop a governance structure supported by documented Terms of Reference and a core membership based upon key stakeholders. Executive sponsors will be required to continue demonstrating strong leadership and shared commitment to ensure the objectives of HARP CDM are met and sustainable change is achieved.

DHS has identified varying levels of care and intensity of service provision for people with chronic and/or complex needs as outlined by Table 1. Key elements of the model of care for HARP CDM are based on the needs of Level 1 and Level 2 service users. These people require intensive community care coordination. This will continue to enhance the usual care they receive from existing community services.

**Table 1: Levels of chronic and complex care management**



Funding made available through HARP CDM will be aimed at establishing HARP CDM across the state. Currently DHS is working toward a funding model.

Efficiencies of scale will be brought about from combining small individual projects into HARP CDM based around a health service. This will allow for greater proportional spending for direct client intervention.

**Early Intervention in Chronic Disease in Community Health Services**

The Early Intervention in Chronic Disease in Community Health Services (EIICDiCHSs) initiative will target people at level 3 of the chronic disease hierarchy, in nine community health services throughout the state. It is acknowledged that the health situation of people with chronic diseases and complex needs will fluctuate. It is imperative that HARP CDM and EIICDiCHSs initiatives complement each other and have established protocols for collaboration.

## Introduction to the Guidelines

The guidelines provide direction for the implementation of HARP CDM. The guidelines are intended to facilitate service provision during the **transition** phase. The transition phase will see a significant number of existing HARP projects mainstreamed and new services established to emerge as HARP CDM.

The key service provision components of HARP CDM required by DHS are stated within these guidelines. The interventions and level of care identified as requirements to meet the guidelines are not prescriptive, allowing for individual services to structure their programs according to local needs. The guidelines will ensure individual services are consistent and available across the service system in an equitable manner.

The guidelines have been developed in accordance with the Evaluation and Quality Improvement Program (EQUIP) framework used by the Australian Council on Healthcare Standards. This framework includes components related to Continuum of Care, Leadership and Management, Human Resources Management, Information Management, Safe Practice and Environment and Improving Performance.

The guidelines should be used in conjunction with organisational quality standards of care, professional codes of conduct, legislative requirements and other regulatory and accreditation healthcare bodies.

Each component of the program guidelines is structured in the following manner:

- Program Guideline**, description of the required service component;
- Rationale**, outline of the reasons for the guideline; and
- Minimum Requirements**, recommendations to assist services in implementing the guidelines.

For the purpose of this document the term "care coordination" has been used as the generic term for the multitude of coordinating roles in existence for people with chronic and complex needs, within HARP CDM. This includes "case management", "care management", "service coordination" and "key worker" roles. Within Levels 1 and 2 it is understood that the intensity of care coordination will vary depending on the client's needs. In some instances clients may need significant input from the care coordinator while others may need more emphasis on referral to appropriate services. The decision to use one generic term has been made to create consistency across HARP CDM and in recognition of the fluctuating and diverse needs of clients.

For the purpose of this document "case management" refers to programs such as Linkages, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) Packages. HARP CDM may refer clients to existing case management services as required.

It is anticipated that the guidelines will be reviewed and revised over time to ensure they reflect the evolution of HARP CDM.

## Glossary of Terms

### *Ambulatory care*

Care that takes place as a day attendance at a health care facility or at the consumer's home. This umbrella term incorporates: primary, secondary and tertiary level services, services provided to individuals or populations, services provided on a same day basis and acute episodic or longitudinal care.

### *Assertive outreach*

The provision of intensive support for people with complex psychosocial needs and psychiatric illness who may require repetitive contact in the community to engage them in the proactive management of their condition.

### *ATSI*

Aboriginal and Torres Strait Islander.

### *Avoid Duplication*

Where a service exists it is the intent to build the capacity of the provider rather than establishing another service that will provide a similar service.

### *Brokerage funds*

Funds specifically allocated for the purchase of services or packages of care for clients enrolled in HARP CDM. May include, but is not limited to interpreter costs, private allied health, food services, short-term private home care, purchase of equipment and transport escort services.

### *Care coordination*

For the purpose of this document the term "care coordination" has been used as the generic term for the multitude of coordinating roles in existence for people with chronic and complex needs. This includes case management, care management, service coordination and key worker roles. Within Levels 1 and 2 it is understood that the intensity of care coordination will vary depending on the client's needs. In some instances clients may need significant input from the care coordinator while others may need more emphasis on referral to appropriate services. The decision to use one generic term has been made to create consistency across HARP CDM and in recognition of the fluctuating and diverse needs of clients.

### *Care planning*

A process to outline how the issues identified in an assessment or review of the client's needs are to be best managed. This may involve linking into a range of existing services, how self management and education are to be provided and involves setting up communication between the General Practitioner and other people involved in providing care to the client. Care planning involves balancing competing needs, and assisting consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.

### *Carer*

A person who "... provides unpaid care and support to family members or friends who have a chronic or acute condition, mental illness, disability or who are frail aged".

### *Case Management*

For the purpose of this document "case management" refers to programs such as Linkages, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) Packages. HARP CDM may refer clients to existing case management services as required.

### *CHF*

Often previously referred to as congestive heart failure (HF). While congestion with fluid retention is commonly present, in some patients congestion is absent so that the term "congestive HF" has been replaced by the broader term "chronic HF".

### *Chronic condition*

A condition of at least six months duration that can have a significant impact on a person's life and requires ongoing supervision by a health professional. Amongst Australia's national health priorities are chronic conditions that are our greatest burdens of disease: asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

### *Chronic Disease Management (CDM) Medicare Items (previously known as Enhanced Primary Care or EPC Items)*

CDM Medicare Benefits Schedule (CDM MBS) items are incentive payments, for GPs to undertake, participate in or review GP Management Plans, Team Care Arrangements, and care planning activities for people with chronic disease and complex care needs. (<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease>)

### *Chronic Heart Disease*

Diseases of the coronary arteries around the heart, frequently leads to heart attacks, includes CHF.

### *Chronic Respiratory Disease*

Includes chronic obstructive pulmonary disease (COPD) and asthma.

### *Client centred*

Delivery of health care configured around the needs of the person.

### *Co-located*

Health services located on the one campus.

### *Community Health Services*

Agencies in receipt of Community Health Program funding that also deliver a wide range of other primary health and support services to meet local community needs. This definition includes gazetted Community Health Centres (with independent Boards of Management as defined in the Health Services Act), primary health units and divisions of rural and metropolitan health services.

### *Community of Practice*

Key representatives from Local Alliances who will work with the Department to develop statewide clinical and operational processes and share learnings through the HARP CDM implementation phase.

### *Community Service Providers*

Agencies located in the community whose core business is to provide services to clients living in the community (including but not limited to Local Government Agencies, Royal District Nursing Service, Community Health Services, General Practitioners, Non-Government Agencies).

### *Complex care needs*

People with complex care needs have multiple health, functional and/ or social issues and are at risk of functional decline and/ or hospital admission. The complexity of the individual's care needs are compounded by the presence of one or more of the following: an unstable or deteriorating condition; increasing frailty and/or dependence; development of complications; co-morbidities; significant change in social circumstances; or three or more hospital admissions in the past twelve months.

### *Complex psychosocial*

Includes psychosocial conditions that have a profound effect on a person's ability to function and their emotional well-being and can include psychotic diseases, drug and alcohol issues, homelessness and clinical depression and anxiety.

### *Comprehensive assessment*

A comprehensive assessment of an individual by a health professional is a multidimensional process that is inclusive of carers and incorporates an in-depth assessment of a person's physical, medical, psychological, cultural and social needs, capabilities and resources.

### *COPD*

Chronic obstructive pulmonary disease (COPD) is the collective term for a number of lung diseases that prevent the lungs from breathing properly. Two of the most common types of COPD are emphysema and chronic bronchitis.

### *DHS*

Department of Human Services.

### *Disease Management*

"...a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant" (Disease Management Association of America).

### *Enhanced Primary Care (EPC)*

See Chronic Disease Management (CDM) Medicare Items.

### *Enrolled Patient Population*

Those clients who have been assessed as eligible and are currently receiving services from or coordinated by HARP CDM.

### *Evidence-based practice*

Evidence-based health care is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Consultation with the client and carer is implicit in the process.

### *General Practitioner (GP)*

A general practitioner (GP) is a registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner:

- Has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care; and
- Maintains professional competence for general practice.

### *Health Service*

The acute and subacute campuses of a Health Service, as well as the additional programs that a Health Service provides in the community. The term "Health Services" has been capitalised to differentiate it from general health care and ongoing community support services delivered by various providers in the community.

### *HealthSMART*

Victoria's Whole-of-Health Information and Communication Strategy. HealthSMART aims to improve patient care, reduce the administrative burden on health care professionals and ease the costs associated with updating technical infrastructure within the public health care system by adopting a more standardised approach to information systems.

### *Hospital Admission Risk Program (HARP)*

Government initiative established to address sustained increases in demand on the hospital system.

### *Integrated care*

Care provided to a client, that is coordinated and connected across the continuum of services and among providers in all sectors and levels.

### *Interdisciplinary approach*

The approach is characterised by the participation and involvement of two or more health disciplines. The different disciplines within a team pool their expertise to make team-based treatment decisions based on the identified client needs.

### *Local Alliance*

The body responsible for overseeing the implementation of HARP CDM within the health service catchment. Includes senior representatives of health services and community based agencies, including but not limited to, representatives from the PCP, the Divisions of General Practice, Community Health Services, Local Government, consumer and carer representation, and other key stakeholders. The Local Alliance is responsible for decision making, accountability and management of risk. Formalised Terms of Reference should document the structures and processes in place for membership, strategic direction, decision making and resolving grievances.

### *Multidisciplinary team*

The team providing HARP CDM is made up of a mix of several relevant disciplines.

### *Older Person*

For the purpose of HARP CDM, an older person is a person aged 70 and over, 50 and over for the ATSI population, or a person with age related illnesses.

### *Outreach Services*

Is the provision of healthcare in a setting away from where the clinician normally practices in order to deliver services that are more easily accessible for the client.

### *Prevention*

There are three types of prevention: primary, secondary and tertiary prevention. Primary prevention is an active, assertive process of creating conditions and or personal attributes that promote the wellbeing of people. Secondary prevention is early detection and intervention to keep initial problems from becoming more severe. Tertiary prevention is the effort to rehabilitate those affected with severe disorders and return them to the community.

### *Primary Care Partnership (PCP)*

A PCP is a voluntary alliance of service providers that work together to improve health and well being in their local communities, as part of the Victorian Government's Primary Care Partnerships Strategy. In Victoria, more than 800 services have voluntarily come together in 31 PCPs (catchments) across the state to progress reforms.

### *Self-management*

"Involves [the person with the chronic disease] engaging in activities that protect and promote health, monitoring and managing symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes" (Flinders Human Behaviour and Health Research Unit).

### *Service Coordination Tool Templates (SCTT)*

The Service Coordination Tool Templates are a suite of tools that have been developed by DHS in consultation with the funded sector. They support service coordination practice by assisting with identifying the initial needs of clients and providing a vehicle to collect and share core client information in a consistent way across diverse programs and agencies. These tools are not assessment tools nor do they replace agency processes.

### *Stakeholder*

A stakeholder is any person, group or organisation that can place claim on an organisation's attention, resources, or output, or is affected by that output.

### *Stratification*

The process of categorising clients into levels of service according to needs.

### *Transition Care*

Provides short-term support and active management for older people at the interface of the acute/sub-acute and residential aged care sectors. It is goal-oriented, time-limited and targets older people at the conclusion of a hospital episode who require more time and support in a non hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements.

### *VAED*

Victorian Admitted Episode Dataset.

### *VEMD*

Victorian Emergency Minimum Dataset.

### *Virtual organisation*

Virtual organisation arrangements consist of networks of workers and organisational units, linked by information and communication technologies, which flexibly coordinate their activities and combine their skills and resources to achieve common goals but without traditional hierarchical modes of central direction or supervision.

# 1. Continuum of care

## 1.1 Defined point of access

### ***Program Guideline:***

HARP CDM is required to provide a defined point of access at the program level for clients, carers and referrers. A defined point of access may be virtual, in that it may consist of several entry mechanisms, but appear streamlined and simple to the referrer. For example, HARP CDM should work towards a single phone number and unified marketing strategy, but may have several strategies for recruiting clients.

Referrers can be hospital inpatient services, hospital outpatient and ambulatory services, community service providers, General Practitioners, potential clients and their carers.

### ***Rationale:***

A defined and known point of access facilitates a smooth referral process for providers referring clients to HARP CDM. A defined point of access for referral, as opposed to multiple options, allows consistency for referrers and assurance that the referral is received by the appropriate source for assessment.

A defined point of access eliminates confusion and ensures ease of contact to HARP CDM for clients and carers. This enables direct access for clients and carers to appropriate services, early medical intervention and information.

### ***Minimum Requirements:***

- Service providers delivering HARP CDM within a defined catchment should collaborate to develop and implement a defined point of access to HARP CDM.
- Policy and procedure describes referral process and contact details for HARP CDM services within hospital and in community-based services.
- Establish agreed mechanisms for communicating contact details including telephone, e-mail and facsimile numbers to referrers.
- Provide contact details to clients and carers; i.e. a fridge magnet with the program's phone number and the name of the care coordinator has been effective for some programs.
- Consider utilising established existing single-point of entry services.
- Develop protocols for referring clients to HARP CDM closer to where the client lives where possible and appropriate, while being mindful that some clients of HARP CDM may access specialists in other geographic locations.

## 1.2 Assessment and stratification

### *Program Guideline:*

In order to determine whether clients are eligible to receive HARP CDM services they will be required to undergo a **screening process**. The screening process will determine clients who are regular hospital users or at risk of avoidable hospital presentations. The screening process will be developed in collaboration with the Community of Practice.

All screened clients determined to be at risk of avoidable hospitalisation and who consent to participate, are enrolled in HARP CDM and comprehensively **assessed**. The needs of carers of enrolled clients also need to be assessed.

All enrolled clients are to be **stratified** based on priority and type of need as determined by the screening process and / or initial assessment findings.

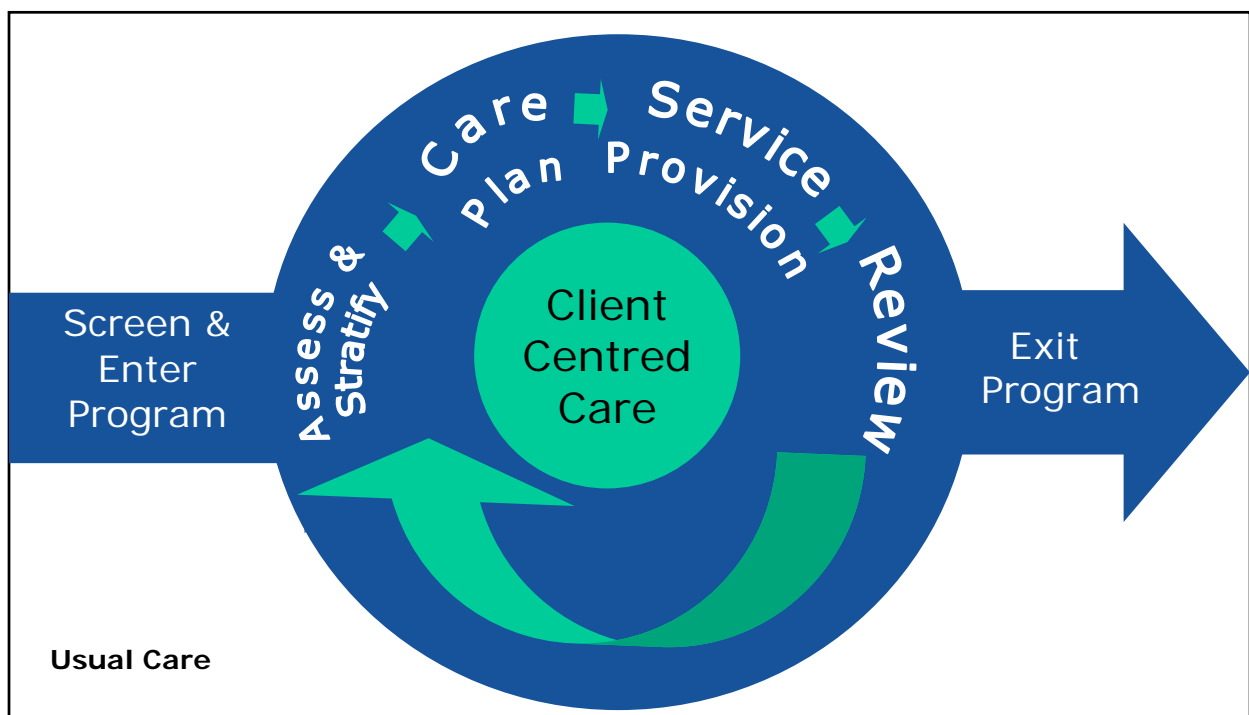
All enrolled clients are to be **reviewed for exit or suspension** from HARP CDM, where there is a period of six months with no additional HARP CDM services to usual care or the client is deriving no measurable benefit from the service.

All enrolled clients are to be **discharged** from HARP CDM in the event of their death or a period of one year with no provision of HARP CDM services. Re-entry for clients who are discharged and who then deteriorate should be smooth. Clients who move out of area need to be referred to the appropriate HARP CDM in that area.

Referrers and the nominated GP are notified of outcome of referral; where the eligibility criteria are met the client is enrolled in HARP CDM and assessed. Where the eligibility criteria are not met the client is not enrolled and feedback is provided to the referrer.

Referrers and the nominated GP are notified of services to be provided.

### **Episode of Care Model**



***Rationale:***

The screening process facilitates appropriate enrolment and appropriate service provision. Only clients meeting criteria are then assessed. A comprehensive assessment identifies issues and needs of the client and ensures appropriate care and management.

Assessing the needs of the carer may assist to prevent carer stress and carer crises and thereby assist in preventing client re-admissions.

Discharging clients when they no longer require HARP CDM services ensures throughput and access for clients who will benefit from HARP CDM.

***Minimum Requirements:***

- Policy and procedure describes processes for intake, assessment, stratification and discharge.
- All clients' and carers' assessments are documented within the client record.
- Referrers are notified of outcome of referral.
- Consider using a tool such as the **InterRAI tool** for client assessment (refer to appendix 1).
- GP is notified of enrolment to HARP CDM and a copy of the assessment (with client consent) is provided.
- Client consent to include referral of information to other agencies, including GPs, Registry of Births, Deaths and Marriages, and DHS (VAED and VEMD).

## 1.3 Care coordination

### ***Program Guideline:***

HARP CDM is required to provide **care coordination** for each client according to need.

HARP CDM is required to ensure:

- Provision of ongoing continuity of care;
- Allocation of a care coordinator;
- Development of a care plan and possibly case conferencing;
- Initiation of supports and services for clients and carers;
- Liaison and communication with service providers including; GPs, specialists and other care providers;
- Provision of information, education, self-management interventions and facilitation of client empowerment;
- Provision of emergency care plan/contacts to clients and carers;
- Access to specialist or multidisciplinary assessment and early intervention when risk of exacerbation or decline;
- Planned reviews and proactive monitoring;
- Management of medication issues, in collaboration with GPs and pharmacists.

### ***Rationale:***

Care coordination facilitates the provision of appropriate supports and services for clients and carers. It ensures continuity of care, integration, and a collaborative care plan and fosters communication amongst the client, carer and all providers in all sectors.

Care coordination assists clients and carers to navigate the service system and facilitates the provision of proactive care. Integration is recognised as an essential component in the management of chronic disease and complex care needs.

### ***Minimum Requirements:***

- Policy and procedure articulates care coordination and describes the criteria for undertaking assessments and developing care plans.
- A care plan is developed which includes client goals and needs, self-management strategies, carer needs, ongoing proactive monitoring, regular review mechanisms and appropriate recommendations from evidence based clinical guidelines.
- The care plan is developed with active participation by client and carer and relevant community services including GPs and is shared by all parties involved in providing care.
- Care coordinators are oriented to and use assessment tools, documentation processes, care planning, local Primary Care Partnership protocols and Chronic Disease Management Medicare items (Formerly Enhanced Primary Care or EPC).
- Care coordinators operate across hospital-community boundaries and should be located in the most appropriate setting to best meet clients' needs and their own needs in relation to having access to decision making, peer support, communication and service efficiency.

## 1.4 Monitoring and review

### ***Program Guideline:***

HARP CDM is required to proactively monitor and review clients.

### ***Rationale:***

Clients will benefit from proactive monitoring as it can disclose early warning signs of disease exacerbation, complex psychosocial issue or need for additional service provision. This allows for the initiation of an intervention or treatment at an early stage. Proactive management can reduce the need for, or extent of, acute healthcare utilisation. Disease management strategies have demonstrated reductions in hospital admissions, improved outcomes of care, improved processes or demonstrated improvements in risk factors for clients with chronic disease.

### ***Minimum Requirements:***

- Policy and procedure articulates` monitoring and review processes.
- Mechanisms for proactive monitoring are developed and documented in care plans. This may be via:
  - Client self monitoring;
  - Telephone contact;
  - Community-based clinic;
  - GP review;
  - Specialist clinic review;
  - Remote monitoring, teleconferencing and/or videoconferencing in rural and regional areas;
  - Outreach / home visits;
  - A combination of the above.
- Consider the frequency of reviews that are appropriate for clients and develop standards and pathways. Ensure all clients are reviewed in an ongoing manner until discharged and that all contacts are documented within client record and care plan. Ensure crisis reviews can be undertaken.
- Facilitate prompt review by appropriate services where deterioration is noted.
- Schedule additional reviews at early stage of disease relapse or exacerbation of complex psychosocial issues.
- Develop parameters for proactive self-monitoring which are appropriate for clients, for example: weight monitoring for clients with heart failure.
- Review and consider the changing needs of the carer.
- Develop protocols or algorithms that support proactive interventions, for example: physician notification and medication review for CHF clients with fluid weight gain.
- Housebound and nursing home clients have access to outreach services where necessary.

## **1.5 Interdisciplinary approach and multidisciplinary team**

### ***Program Guideline:***

HARP CDM is required to provide an interdisciplinary approach to client care with access to a multidisciplinary team that works across hospital and community boundaries. This requires partnerships to be firmly established as part of the work practice for staff employed and begin as part of the recruitment and orientation of staff to HARP CDM.

### ***Rationale:***

Clients require expertise from multiple disciplines to ensure needs are considered comprehensively.

An interdisciplinary approach adopts a more client centred approach in that the focus shifts from a discipline specific approach to treatment and towards the different disciplines within a team pooling their expertise to make team based treatment decisions based on the needs of the client.

### ***Minimum Requirements:***

- An interdisciplinary approach with access to a multidisciplinary team is established that may include hospital, community providers and GPs working in partnership.
- Facilitate knowledge, and recognition of each discipline's skill sets.
- Ensure that a comprehensive assessment of the client is undertaken by one team member, and that referrals to specialists are made where appropriate.
- Foster team approaches to care across disciplines by ensuring all members of the team are aware of the findings of the assessment, the details of the care plan and the monitoring review processes.
- Ensure systems are in place to understand the cultural context of clients and meet their requirements. This will include, but not be limited to, access to interpreter services where necessary either in person or via telephone.
- Utilise education and information material in multiple languages where necessary.
- Facilitate access to Aboriginal and Torres Strait Islander (ATSI) Liaison Officers as required.
- In rural areas, form links with other services and build capacity through education, mentoring and skill sharing where there are workforce shortages.
- In rural areas link with major regional services through teleconferencing and videoconferencing for client reviews and for staff education.

## 1.6 Education and self-management

### ***Program Guideline:***

The principles of self-management should underpin all interactions between clients/carers and clinicians. HARP CDM is required to tailor education, client empowerment and self-management services to meet the personality, learning styles, cultural and language needs, and cognitive ability of clients and/or carers. There is a range of ways in which self-management principles can be delivered and clinicians should explore the most effective method for the individual.

### ***Rationale:***

Self-management programs have an impact on client wellbeing. Clients who have an understanding of how to prevent exacerbation of their disease will assist in maintaining optimal health.

### ***Minimal Requirements:***

- Policy and procedures articulate education process for clients and carers.
- The education process should:
  - Provide education using principles of adult learning and in account with cultural and literacy factors;
  - Include the client's carer and family in the education program;
  - Utilise a variety of education formats such as audio, video, written, group and individual sessions;
  - Provide education topics that are relevant to chronic disease such as anxiety and depression, fatigue management, energy conservation;
  - Offer specific carer education sessions that include topics such as: caring for yourself, carer loss and grief, planning for residential respite, communicating with healthcare professionals;
  - Provide written education material in multiple languages as necessary;
  - Ensure the education plans and participation are documented in each client's record and care plan;
  - Ensure the education schedule is ongoing;
  - Provide education information that is consistent across the multidisciplinary team.
- Assess client and carer suitability for self-management programs.
- Tailor the self-management approach to the capacity of the client and carer.
- Encourage client and carer involvement in own management.
- Encourage collaboration between clinicians, clients and carers.
- Provide clients with a copy of their care plan and suggest that clients use symptom diaries and action plans where appropriate.
- Document level of self-management and behaviour change in each client's record and care plan.
- Consider utilising tools such as "Partners in Health Scale, Cue and Response Interview, Problems and Goals assessment tools" (Refer to appendix 1).
- Consider a leader training program (Refer to appendix 1).
- Consider accessing education resources through foundations and national health bodies (refer to appendix 1).

## 1.7 Role of General Practitioner

### ***Program Guideline:***

HARP CDM is required to request that clients nominate a GP. Where a client does not have a GP, HARP CDM should arrange for the client to be referred to an appropriate GP (where feasible).

HARP CDM is required to notify the client's GPs of client enrolment.

HARP CDM is required to actively engage with the GP and provide the GP with documentation on the care plan, services initiated, tests arranged, follow up appointments and medications.

HARP CDM is required to accept appropriate referrals from GPs and provide regular information on client progress, and with client consent, GPs should also provide information via care planning/review.

### ***Rationale:***

GPs are integral in client management, especially medical management. Exchange of information and shared care planning will improve continuity of care. Through building strong professional relationships, GPs can play an important role for HARP CDM in client identification, assessment, care planning and review.

### ***Minimum Requirements:***

- Policy and procedure articulates process for notification of the client's enrolment in HARP CDM to the GP as well as process for shared plan of care.
- In consultation with Divisions of General Practice, establish process for arranging an appropriate GP for a client to be referred to when that client does not have a GP.
- Develop a robust communication process to ensure information is shared in a concise and timely manner between HARP CDM and the GP.
- Provide verbal information via phone for urgent issues.
- Provide written information by electronic transfer, fax or mail.
- Relay relevant results of investigations to avoid duplication.
- Facilitate information gathering from GP.
- Utilise Chronic Disease Management Medicare items (formerly EPC items) for care planning and review, to facilitate GP involvement.
- Ensure skill sharing with the GP and encourage joint management with specialists.
- Provide notification and discharge summary to GP when client is discharged from HARP CDM.
- GPs to provide access to yearly influenza and pneumococcal vaccinations.

## 1.8 Psychosocial support

### ***Program Guideline:***

The term 'psychosocial needs' is used broadly to include drug and alcohol related problems, as well as problems associated with homelessness. For patients who are psychiatrically acutely unwell, treatment and/or admission by the area mental health service is the most appropriate response. However, a large number of patients present with the following problems which, on assessment, are not deemed to require acute psychiatric services:

- Depression and anxiety;
- A personality disorder;
- Drug and/or alcohol problems;
- Problems related to homelessness or being at risk of homelessness; or
- Any or all of the above.

HARP CDM is required to provide services to clients with:

- A primary diagnosis of psychosocial needs, such as a personality disorder, substance abuse and homelessness; and
- A secondary diagnosis of psychosocial needs, such as depression and anxiety, as a result of another chronic condition, which may cause considerable impact to the person's functioning and emotional well-being.

HARP CDM also provides psychosocial support to enrolled clients with chronic disease.

### ***Rationale:***

Clients with complex psychosocial needs require expertise and services for appropriate management to reduce dependence on hospital-based services and improve quality of life.

Many clients with chronic disease experience anxiety and/or depression. This can have a significant impact on quality of life and the ability to self-manage. Addressing anxiety and depression may improve clients' quality of life and condition management.

### ***Minimum Requirements:***

- Policy and procedure articulates psychosocial support, services and referrals within HARP CDM.

#### **Clients with a primary diagnosis of psychosocial needs**

- Facilitate links to specialised services such as drug and alcohol services, mental health, housing services, forensic, social recreation support services, employment, personal care and chronic pain management and other organisations that support the homeless.
- Facilitate links to mental health services for clients with complex psychosocial and/or psychiatric needs (refer to appendix 1).
- Ensure there is access to assertive outreach and intensive case management.
- Ensure that care provided is consistent with the Mental Health Act.
- Ensure that clinicians are encouraged to engage with the clients using an assertive style.
- Ensure care coordinators primarily dealing with clients with a secondary diagnosis of psychosocial needs have access to clinicians with experience in treating the physical symptoms associated with their illness.

### **Clients with a secondary diagnosis of psychosocial needs**

- Consider management strategies for depression and anxiety including pharmacological management, psychology and cognitive behavioural therapy, outreach programs, exercise rehabilitation and client and carer support programs such as counselling, GP support, and mental health services.
- Provide access to resources and guidelines on the management of anxiety and depression (refer to appendix 1).
- Facilitate links to primary mental health and counselling services to assist with the management of anxiety and depression.
- Consider employing psychologists and clinicians with mental health training as members of HARP CDM team.

## 1.9 Specialist services

### ***Program Guideline:***

HARP CDM is required to provide or facilitate client access to the following specialist services where required:

- Specialist physicians, for example: cardiologists, respiratory physicians, geriatricians, psychiatrists;
- Medical investigations;
- Pharmacists, medication education and review services;
- Rehabilitation services;
- Allied health services;
- Case Management services (eg. Linkages, Community Aged Care Packages, Extended Aged Care at Home Packages);
- Paediatric services;
- Home nursing services for example: wound management, continence, stomal therapy, palliative care;
- Specialist clinics, for example: falls and mobility, continence, chronic pain, and cognitive dementia and memory services;
- Carer support services, for example: respite;
- Mental health services;
- Drug and alcohol services;
- Palliative care;
- Specialist nurse practitioners and educators, for example: respiratory disease nurse;
- Aged Care Assessment Services;
- Secondary consultations in psychosocial;
- ATSI Liaison Officers;
- Housing Services.

HARP CDM is required to utilise evidence based clinical guidelines for clients who have chronic heart or respiratory illnesses.

Culturally and linguistically diverse clients and carers are to have access to appropriate resources to facilitate care. Aboriginal and Torres Strait Islander clients have access to services that meet their needs.

### ***Rationale:***

Clients with chronic and complex needs require a comprehensive service to optimise outcomes.

Clients with chronic and complex needs may benefit from periodic review by a medical specialist and those with polypharmacy issues and in need of medication management education will most likely benefit from a service such as a home medication review.

The use of rehabilitation has demonstrated positive outcomes for patients with CHF and COPD.

Carers play a significant role in supporting the client and require support to prevent significant impact on their own wellbeing. Services such as support groups and respite may assist carers and potentially reduce the impact of carer stress.

### ***Minimum Requirements:***

- Policy and procedure articulates access to specialist services.
- Develop mechanism for medical review and reporting.

- Maximise access to existing rehabilitation programs, specialised clinics and specialised services.
- Ensure practice is based upon best available evidence.
- Staff have access to evidence based guidelines (refer to appendix 1).
- Facilitate access to carer support resources and counselling such as Carers Victoria (refer to appendix 1).
- In rural areas develop mentoring relationships between agencies to assist in the establishment of services in sub-regional health services.

## **1.10 Flexible service provision**

### ***Program Guideline:***

HARP CDM is required to provide access to a wide range of services, where required that include after hours and outreach services. This may require purchasing one-off services and brokerage services.

### ***Rationale:***

Service gaps prevent the provision of adequate support and may lead to representation or admission to hospital. The purchase of specific services addresses gaps until usual services are available. This potentially reduces the risk of readmission.

Some clients with complex psychosocial needs require assistance with basic necessities such as food and housing before their healthcare needs can be addressed.

### ***Minimum Requirements:***

- Each local alliance has access to brokerage funds.
- Policy and procedure articulates process for accessing and monitoring brokerage funds.
- Consider linking with existing brokerage services.
- Ensure quality of purchased service.
- Ensure adequate communication and coordination occurs.

## 1.11 24-hour advice

### ***Program Guideline:***

HARP CDM is required to provide advice to clients and carers on how to access information and services on a 24-hour basis.

HARP CDM is required to provide all clients and carers with contact details.

### ***Rationale:***

Clients with chronic and complex care needs may have an exacerbation or need for assistance outside usual working hours. Access to services may result in early intervention and reduce dependence on hospital emergency department services.

### ***Minimum Requirements:***

- Policy and procedure articulates process for accessing 24-hour advice. This may be via:
  - Call centre
  - Outreach service
  - Brokered service
  - GP
  - Emergency Department
  - Mental Health Services
- Develop an emergency care plan for clients and carers, which includes 24-hour contact details.
- Where possible provide client information to after hours service staff.

## 1.12 Referral and links to other services

### ***Program Guideline:***

HARP CDM is required to have established referral processes.

Referrals to all required supports and services are to be made as soon as possible to avoid lengthy delays. HARP CDM is required to send written documentation of referral within same day.

Clients are to have access to their previous and usual services whilst HARP CDM provides additional required services.

### ***Rationale:***

Established and agreed referral processes between services will facilitate smooth and timely referrals and avoid delays for client care as well as service duplication.

Services communicating with each other with documented care plans or service needs will ensure continuity of care for clients, improve the quality of care and reduce likelihood of admission to hospital.

Clients who receive continuity of care through appropriate supports and services will have better outcomes.

### ***Minimum Requirements:***

- Policy and procedure articulates liaison/referral process between the interfaces.
- Facilitate the interface between services by building relationships between sectors and developing formal links with community and hospital providers. Services should utilise and/or build on existing PCP referral practices and protocols.
- Establish agreed referral process/documentation to facilitate smooth referral utilising the SCTT (refer to appendix 1).
- Consider holding forums for staff from all services and sectors to gain understanding of each other's roles and responsibilities.
- Written referral documentation is sent electronically, by fax or mail.
- Consider accessing Chronic Disease Management Medicare Items for access to allied health and nursing items.

## 2. Leadership and management

### 2.1 Governance

#### ***Program Guideline:***

A Health Service will manage HARP CDM for a defined population and in partnership with community-based service providers.

Each HARP CDM will have a local alliance that includes representation from hospital and community providers. The membership of the local alliance will be inclusive of all key stakeholders.

#### ***Rationale:***

The governance agreements need to reflect the views of both community and hospital providers and is important for stakeholder and interagency engagement. Agreements should build on existing arrangements, including PCP Memorandum of Understanding (MOU), rather than creating new or duplicative structures.

It is important that the local alliance is representative of all stakeholders, and is able to effectively manage HARP CDM implementation. Representatives should be able to make decisions on behalf of the organisations they represent, and be mindful of the time commitment required to effectively carry out these roles.

The local alliance is responsible for ensuring that the local HARP CDM complies with HARP CDM Guidelines.

#### ***Minimum Requirements:***

- Policy and procedure articulates governance agreements and processes.
- The Health Service should form the local alliance building on existing local partnerships and should strongly consider including at least one representative of a PCP, Division of General Practice, Community Health Service, Local Government, consumer and carer representation, and other key stakeholders.
- Local Alliance Terms of Reference are established.
- The Local Alliance meets regularly to oversee and evaluate service function. Minutes of the meeting are documented.
- Links to relevant Health Service Board Sub Committees are established, for example: Population Health Sub Committee.
- Divisions of General Practice to be represented on the Local Alliance Governance Committee.
- Ensure that there is an agreed process for appropriate sharing of client information between health services, GPs, and community based providers. Existing General Practice Liaison Units should be involved in this process.

## 2.2 Accountability

### *Program Guideline:*

HARP CDM is accountable to DHS through the Health Service.

Information quantifying HARP CDM activity and the level of service provision will be reported to DHS. The Health Service is required to demonstrate that it has provided the service in accordance with these guidelines.

HARP CDM must comply with legislative requirements and be accountable to regulatory bodies such as professional boards of practice and healthcare accreditation bodies.

### *Rationale:*

Accountability facilitates the provision of a quality and standardised HARP CDM for eligible clients in an equitable manner across the Victorian healthcare system. It is through accountability processes that the right services are provided to the right clients in an efficient manner with public funding. Compliance with legislative requirements and healthcare accreditation also facilitates safe and quality programs.

### *Minimum Requirements:*

- Develop policy and procedure manual for the local HARP CDM.
- Policy and procedure articulates accountability and reporting processes.
- Develop formal service agreements with contracted community agencies where appropriate.
- Define roles and responsibilities of service and service provider.
- Define goals of HARP CDM and communicate these to all internal and external providers and clients and carers.
- Monitor HARP CDM and evaluate in an ongoing manner.
- HARP CDM reports activity and other key information to the local alliance in an ongoing manner and is documented in committee meeting minutes.
- Ensure HARP CDM meets other health regulatory requirements such as accreditation.
- Demonstrate implementation of mechanism for receiving and providing feedback to stakeholders, including consumer feedback.
- Local alliances are encouraged to develop a program approach to monitoring HARP CDM.
- Health Services will be required to report on the number of enrolled clients and expenditure acquittal on an annual basis.

**Monitoring and reporting requirements will be developed in consultation with the field during 2005-06.**

### 3. Human resource management

#### 3.1 Staff competency and ongoing education

***Program Guideline:***

HARP CDM is required to select and recruit professionals that have the relevant experience, knowledge, skills and qualifications required by clients.

HARP CDM is required to provide an orientation and relevant learning and development program for employees.

***Rationale:***

The clients enrolled in HARP CDM require healthcare providers with specific skills sets and experience. The selection of appropriate employees facilitates the provision of appropriate care and management. Clients require a team of professionals who are able to assess clinical status and detect disease exacerbation or crises in psychosocial issues as well as possess care coordination skills with an understanding of all internal and external supports and services available for clients.

Learning and development assists providers to provide quality care and management. Learning and development education also assists providers to continue to be competent in their practice.

***Minimum Requirements:***

- Policy and procedure articulates human resource management processes including: staff competency evaluation; role description; performance management and education program.
- Develop job descriptions, which accurately reflect the roles.
- Develop a set of competencies or key performance indicators relevant to the roles and evaluate performance according to those indicators.
- Set clear goals and expectations during performance review process.
- Ensure staff act within their respective professional code of conduct.
- Develop a team environment and a culture of teamwork.
- Ensure every employee receives a comprehensive orientation program that includes orientation to client entry and exit criteria, documentation and assessment forms, internal and external supports, services and providers, policies and procedures, HARP CDM Guidelines.
- Develop a staff learning and development program. Consider:
  - Carers Victoria workshops for senior and direct care staff (refer to appendix 1);
  - Relevant conferences and workshops;
  - Cultural sensitivity training;
  - Invite external services to present in staff forums/meetings.
- Purchased services for the program should comply with the above.
- HARP CDM staff members are required to share expertise within the local HARP CDM and with other health and community providers.

## **3.2 Professional accountability**

### ***Program Guideline:***

HARP CDM is required to ensure employees understand they are accountable for their practice and act within respective professional codes of practice.

### ***Rationale:***

The goal of professional accountability is to support healthcare providers in the conduct of their practice. Professional accountability ensures individuals are accountable for their own practice. Professional accountability assists in the delivery of safe and competent care for clients enrolled in HARP CDM. It is also essential that professionals adhere to the scope of their practice and act in accordance with legislative requirements.

### ***Minimal Requirements:***

- Policy and procedure articulates professional accountability processes.
- Employees are qualified professionals and registered with the relevant body.
- Employees are professionals with an awareness of their professional accountability and code of practice.

## 4. Information management

### 4.1 Client record management

#### ***Program Guideline:***

HARP CDM is required to ensure all relevant client information is accurately and clearly documented within a client record; including assessments, clinical information, updates, consultations, reviews, referrals, education, care plans, medication lists and contacts.

HARP CDM is required to ensure all client records are kept in a safe and secured environment consistent with the wider organisational policy.

HARP CDM is required to ensure that client record information is shared amongst services where there is documented client consent to do so.

#### ***Rationale:***

The client record provides the multidisciplinary team with all relevant client information and the plan of care that is required for consistency and continuity of care.

The client record may reduce duplication of activities such as client assessment and pathology.

#### ***Minimum Requirements:***

- Policy and procedure articulates the client record management processes including a policy on the interagency transfer of information.
- Employees have adequate orientation to client record documentation processes.
- Client record documentation is consistent with the organisations' policy and processes.
- Documentation is clear and that abbreviations are understood.
- Establish documentation requirements from external agencies.
- Establish secure information exchange processes between agencies and service providers.
- All client records contain all relevant client information.
- All client record information is shared between services where there is documented client consent to do so.

#### **ICT Connectivity**

The Department has invested \$30 million between 2001-02 and 2004-05 as part of the 'Growing Victoria Together' initiative to improve connectivity between primary care providers and between the primary and acute sectors through the provision of broadband technologies. This enhanced connectivity provides a secure and reliable network, which supports electronic referral and sharing of data and software applications such as client management systems. It is anticipated that 450 prioritised agencies will be connected across the state under this initiative.

## 4.2 Privacy and consent

### ***Program Guideline:***

HARP CDM is required to ensure that informed consent is obtained from all clients for the sharing of personal information and referrals amongst services.

HARP CDM is required to ensure that the medium for transfer of client record information is safe and consistent with privacy laws.

### ***Rationale:***

Clients have the right to protect their privacy and the confidentiality of their own information without impacting on the right to ongoing treatment and care.

Clients also have the right to know which agencies and individual providers their information is being shared with, and the purpose of sharing their information, in order to make an informed decision about releasing their information.

### ***Minimum Requirements:***

- Policy and procedure articulates client consent process.
- Use the SCTT consent form and associated guidelines for gaining consent to be involved in HARP CDM and to share information.
- Client consent to include referral of information to other agencies, including GPs, Registry of Births, Deaths and Marriages, and DHS (VAED and VEMD).
- Provide client information sheets on information exchange between services so that clients understand the purpose of information sharing and the process involved.
- Employees are aware that client consent is part of the documentation process and is required prior to sharing client information with external agencies.
- The client privacy processes are consistent with privacy laws and wider organisational policy such as identifying the requestor of information and identifying the correct client.
- All clients have consent documentation in the client record.

### **4.3 Program data and outcomes**

***Program Guideline:***

HARP CDM will be required to collect and self monitor **program data and healthcare utilisation data**.

***Rationale:***

The monitoring and analysis of data allows programs to evaluate the quality of the service and thereby facilitate the quality improvement process.

Program data examines activity, growth and capacity and therefore assists in program planning and determining future requirements. Data analysis also determines effectiveness and viability.

***Minimum Requirements:***

- Policy and procedure articulates data collection and self-monitoring processes.

## 5. Safe practice and environment

### 5.1 Risk management and staff safety

#### ***Program Guideline:***

HARP CDM is required to identify risks and manage them in order to minimise adverse events and optimise the safety of clients and staff.

#### ***Rationale:***

The identification of risks enables the implementation of strategies to avoid or minimise events of an adverse nature. It also enables services to optimise client and staff safety.

#### ***Minimum Requirements:***

- Policy and procedure articulates risk management process.
- Link HARP CDM risk management strategy into the wider organisation's risk management plans.
- Identify and document risks and determine severity of risk in a risk management plan.
- Determine strategies for avoiding risk, for example: supervision, audit programs, and preventative maintenance.
- Ensure staff education and policy manuals includes relevant procedures (if applicable) for
  - Travelling in cars;
  - Home visit guidelines;
  - Working in isolation;
  - Critical incident management;
  - Manual lifting and handling;
  - Infection control;
  - Handling hazardous materials;
  - Clinical emergency procedures such as cardiopulmonary resuscitation, relevant assessment skills to client needs, for example: detection of deterioration in health status, risk of self-harm; and
  - Risk screening of the environment for outreach care.

## 6. Improving performance

### 6.1 Quality improvement plan

***Program Guideline:***

HARP CDM is required to implement an annual quality improvement plan.

***Rationale:***

Quality improvement optimises client care by providing evidence of outcomes and identification of areas for enhancement. It is essential to the delivery of a safe and quality service.

Quality improvement demonstrates a commitment to improving performance in care and service delivery.

***Minimum Requirements:***

- Policy and procedure articulates quality improvement process.
- Incorporate ongoing monitoring and outcomes analysis into everyday practice.
- Ensure outcomes analysis is consistent over time to compare the program with specific indicators and evaluate improvement.
- Monitor and respond to adverse events.
- Facilitate a quality improvement culture within HARP CDM.
- Conduct client experience surveys.
- Conduct staff experience surveys.
- Evaluate budget efficiency.
- Evaluate strategic planning achievements.
- Evaluate frequency of local alliance meetings and attendance rates.
- Facilitate staff development, competency and provide learning and development opportunities.

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## Appendix 1: Resources

### Assessment tool

The interRAI tool is a validated tool for comprehensive assessment of clients with complex needs. The interRAI tool provides a consistent set of data on individuals that can be utilised by all providers across settings. There are various versions for different types of client groups: Residential / long term care, home care, acute care, post acute care, palliative care and mental health (Gray, L. 2003); <http://www.interrai.org> or <http://www.interrai-au.org>

### Carers

Carers Victoria: website [www.carersvic.org.au](http://www.carersvic.org.au) or 1800 242 636

### Chronic Disease Management (CDM) Medicare Items (previously known as Enhanced Primary Care or EPC Items)

- <http://www.health.gov.au/internet/wcms/publishing.nsf/Contnt/pcd-programs-epc-chronicdisease>

### COPD

- American Thoracic Society. Guidelines for COPD Management. [www.thoracic.org/COPD/](http://www.thoracic.org/COPD/)
- Australian Lung Foundation. The COPDX Plan: The Australian and New Zealand Guidelines for the Management of COPD 2003. [www.lungnet.org.au](http://www.lungnet.org.au)
- National Institute for Research Excellence (NICE UK) Management of COPD in adults in primary and secondary care. [www.nice.org.uk/pdf/CG012\\_niceguideline.pdf](http://www.nice.org.uk/pdf/CG012_niceguideline.pdf)
- Global Initiative for Chronic Obstructive Lung Disease. Pocket guide to COPD diagnosis, management and prevention (2004) [www.goldcopd.com](http://www.goldcopd.com)

### Complex psychosocial

- Adult mental health services  
[www.health.vic.gov.au/mentalhealth/services/adult/index.htm](http://www.health.vic.gov.au/mentalhealth/services/adult/index.htm)
- Aged persons mental health services  
[www.health.vic.gov.au/mentalhealth/services/aged/index.htm](http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm)

### Department of Human Services Policies

- Ambulatory Care Policy and Planning Framework  
<http://www.health.vic.gov.au/ambulatorycare/>
- Early Intervention in Chronic Disease in Community Health Services
- HealthSMART <http://www.dhs.vic.gov.au/ahs/healthit.htm>
- Improving Care for Older People <http://www.health.vic.gov.au/older/>

### Depression and anxiety

- Australian Beyond Blue resources [www.beyondblue.org.au](http://www.beyondblue.org.au)
- Victorian Department of Human Services: Mental Health Services.  
[www.health.vic.gov.au/mentalhealth/illnesses/depression.htm](http://www.health.vic.gov.au/mentalhealth/illnesses/depression.htm)

### Education resources

- Australian Lung Foundation [www.lungnet.orgt.au](http://www.lungnet.orgt.au)
- Heart Support Australia [www.heartnet.org.au/home.html](http://www.heartnet.org.au/home.html)
- Cardiomyopathy Association of Australia [www.cmaa.org.au](http://www.cmaa.org.au)
- Stanford/Lorig Programs are conducted through Arthritis Victoria (Phone: 8531 8008)

### Education tool

- "Partners in Health Scale, Cue and Response Interview, Problems and Goals assessment tools" by the Human Behaviours and Health Research Unit at Flinders University for assessment and client goal setting; <http://som.flinders.edu.au/FUSA/CCTU/Home.html>.

### **Heart failure**

- Australian Heart Foundation. Guidelines on the Contemporary Management of CHF. [www.new.heartfoundation.com.au/downloads/cont.management.pdf](http://www.new.heartfoundation.com.au/downloads/cont.management.pdf)
- National Institute for Research Excellence (NICE UK) NICE Guidelines on the management of CHF in Primary and Secondary Care. [www.rcplondon.ac.uk/pubs/books/CHF/heartfailure.pdf](http://www.rcplondon.ac.uk/pubs/books/CHF/heartfailure.pdf)
- American College of Cardiology / American Heart Association. ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult. [www.acc.org/clinical/guidelines/failure/hf\\_index.htm](http://www.acc.org/clinical/guidelines/failure/hf_index.htm)

### **SCTT form**

The SCTT form is a statewide service coordination template developed by the DHS that facilitates the sharing of information and assessments amongst all services including community and acute sectors.

<http://hnb.dhs.vic.gov.au/rrhacs/phkb/phkb.nsf/AllDocs/AAD6521FA6761C15CA256CB>